CMS Manual System

Pub 100-19 Demonstrations

Transmittal 23

Department of Health & Human Services

Center for Medicare and & Medicaid Services

Date: MAY 6, 2005

Change Request 3816

SUBJECT: Low Vision Rehabilitation Demonstration

I. SUMMARY OF CHANGES: Full Replacement of CR 3629, CR Title. CR 3629 is rescinded Under this Low Vision Rehabilitation Demonstration, Medicare is extending coverage under Part B for the same services to treat vision impairment that would otherwise be payable when provided by an occupational or physical therapist if they are now provided by a vision rehabilitation professional under the general supervision of a qualified physician. This demonstration shall last for five years through 10/01/10 and is limited to services provided in specific demonstration states. Payment for vision rehabilitation services under this demonstration may be made to either the qualified physician supervising the vision rehabilitation professional or a qualified facility, such as a rehabilitation agency or clinic that has a contractual relationship with the vision rehabilitation professional and where the services are furnished under the individualized written plan of care. Payment for these services shall be made under the physician fee schedule even when such services are billed by a facility. They are not subject to bundling under the outpatient prospective payment system (OPPS).

NEW/REVISED MATERIAL :
EFFECTIVE DATE : October 01, 2005
IMPLEMENTATION DATE : October 03, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-19	Transmittal: 23	Date: May 6, 2005	Change Request 3816

SUBJECT: New Requirements for Low Vision Rehabilitation Demonstration Billing

I. GENERAL INFORMATION

A. Background:

As part of the appropriations conference report to accompany H.R. 2673, the Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project in selected sites across the country to examine the impact of standardized national coverage for vision rehabilitation services provided in the home by physicians, occupational therapists and certified low vision therapists, rehabilitation teachers, and orientation and mobility specialists. The demonstration will be carried out over a period of 5 years.

A Program Memorandum (Transmittal AB-02-078) issued May 29, 2002 contains a Provider Education Article to alert physicians and the provider community that Medicare beneficiaries who are blind or visually impaired are eligible for physician prescribed rehabilitation services from approved health care professionals (qualified physician, occupational therapist, physical therapist) on the same basis as beneficiaries with other medical conditions that result in reduced physical functioning. Several Medicare carriers have written Local Coverage Decisions (LCDs) with respect to this transmittal. However, current regulation prohibits low vision professionals from furnishing services even if it is incident to physician's services. The demonstration will permit low vision rehabilitation professionals to provide services in the home, or office, or clinic under general supervision by the physician.

B. Policy:

Under this Low Vision Rehabilitation Demonstration, Medicare will cover low vision rehabilitation services to people with a diagnosis of moderate or severe vision impairment not correctable by conventional methods of spectacles or surgery. Services shall be provided under an individualized, written plan of care developed by a qualified physician or qualified occupational therapist in private practice (OTPP) that is reviewed at least every 30-days by a qualified physician. The plan of care must attest that vision rehabilitation services are medically necessary and the beneficiary receiving vision rehabilitation is capable of receiving rehabilitation and deriving benefit from such services, and should include:

- An initial assessment which documents the level of visual impairment;
- Specific measurable goals to be fulfilled during rehabilitation and the criteria by which the goals will be measured;
- Description of specific rehabilitative services to be directed toward each goal provided during the course of rehabilitation; and
- A reasonable estimate of the amount of treatment necessary to reach the goals.

Rehabilitative services shall be conducted within a 3-month period of time, in intervals appropriate to the patient's rehabilitative needs, and shall not exceed 24 units of service of 15 minutes each, or the equivalent

of 6 hours in total. Rehabilitation will be judged completed when the treatment goals have been attained and any subsequent services would be for maintenance of a level of functional ability, or when the patient has demonstrated no progress on two consecutive visits. All services covered under this demonstration are one-on-one, face-to-face services. Group services will not be covered.

Vision rehabilitation services shall be furnished in an appropriate setting, including the home of the individual receiving the services, as specified in the plan of care. Vision rehabilitation services can be provided by a qualified physician as defined in §1861 (r) (1) and (4) of the Social Security Act, or by a qualified occupational therapist in private practice, or a qualified occupational therapist who is an employee of the physician, or a vision rehabilitation professional who is certified by the Academy for Certification of Vision Rehabilitation & Education Professionals (ACVREP). Occupational therapists employed by the physician and certified vision rehabilitation professionals may furnish services while under the general supervision of a qualified physician. General supervision means that the physician does not need to be "on premises" nor in the immediate vicinity of the rehabilitation services as would be the case with "incident to" requirements stated in Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 60.1 B.

A qualified physician is defined for this demonstration as a physician who is an ophthalmologist or a doctor of optometry. Certified vision rehabilitation professionals include low vision therapists, orientation and mobility specialists, and vision rehabilitation therapists who have received certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

Payment for vision rehabilitation services shall be made to the qualified physician under the Physician Fee Schedule (PFS) or to a facility, including hospitals, comprehensive outpatient rehabilitation facilities (CORF), other rehabilitation agencies or clinics, or facilities that bill Medicare for providing occupational therapy, through which services are furnished under an individualized, written plan of care. Occupational therapists in private practice may also submit claims under their own provider number for providing low vision rehabilitation services. However, claims submitted by occupational therapists in private practice must contain the same information as on a physician's claim form and must use the demonstration procedure, or "G", code for occupational therapists for the claim to be considered. Occupational therapists in private practice may not supervise therapy assistants or low vision rehabilitation professionals, nor may they submit claims for the services of these individuals under the demonstration. Certified vision rehabilitation professionals provide services pursuant to a plan of care and under the general supervision of the qualified physician who develops the plan of care. However, if the certified vision rehabilitation professional has a contractual arrangement with the facility where services are furnished, the facility may submit the bill for services. Payment to practitioners and facilities shall be made using the Medicare Physician Fee Schedule (MPFS) with jurisdictional pricing; vision services covered under the demonstration provided in a hospital outpatient setting will not be paid under the OPPS system. Payment for services under this demonstration is limited to low vision rehabilitation. Evaluation and maintenance services are not billable under the demonstration.

Vision impairment refers to significant vision loss from disease, injury or degenerative condition that cannot be corrected by conventional means, such as medication or surgery. The impairment must be manifest by one or more of the following conditions:

Levels of Vision Impairment	Description

Moderate Visual impairment	Best corrected visual acuity is less than 20/60 in the better eye (including a range of 20/70 to 20/160)
Severe visual impairment (legal blindness)	Best corrected visual acuity is less than 20/160 including 20/200 to 20/400; or visual field diameter is 20 degrees or less (largest field diameter for Goldman isopter III4e, 1/100 white test object or equivalent) in the better eye.
Profound visual impairment (moderate blindness)	Best corrected visual acuity is less than 20/400, or visual field is 10 degrees or less.
Near-total visual impairment (severe blindness)	Best corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less.
Total visual impairment (total blindness)	No light perception

The following ICD-9-CM diagnosis codes shall be used to support medical necessity for coverage under the demonstration.

ICD-9-CM Codes that Support Medical Necessity

368.46	Homonymous Bilateral Field Defect
368.47	Heteronymous Bilateral Field Defect
369.01	Better Eye: Total Impairment Lesser Eye: Total Impairment
369.03	Better Eye: Near-Total Impairment Lesser Eye: Total Impairment
369.04	Better Eye: Near-Total Impairment Lesser Eye: Near-Total Impairment
369.06	Better Eye: Profound Impairment Lesser Eye: Total Impairment
369.07	Better Eye: Profound Impairment Lesser Eye: Near-Total Impairment
369.08	Better Eye: Profound Impairment Lesser Eye: Profound Impairment
369.12	Better Eye: Severe Impairment Lesser Eye: Total Impairment

369.13	Better Eye: Severe Impairment Lesser Eye: Near-Total Impairment
369.14	Better Eye: Severe Impairment Lesser Eye: Profound Impairment
369.16	Better Eye: Moderate Impairment Lesser Eye: Total Impairment
369.17	Better Eye: Moderate Vision Impairment

	Lesser Eye: Near-Total Vision Impairment
369.18	Better Eye: Moderate Vision Impairment Lesser Eye: Profound Vision Impairment
369.22	Better Eye: Severe Vision Impairment Lesser Eye: Severe Vision Impairment
369.24	Better Eye: Moderate Vision Impairment Lesser Eye: Severe Vision Impairment
369.25	Better Eye: Moderate Vision Impairment Lesser Eye: Moderate Vision Impairment

Most rehabilitation is short-term and intensive, and sessions are generally conducted over a consecutive 90-day period of time with intervals appropriate to the patient's rehabilitative needs. Patients usually receive therapy 1-2 times per week, and not less frequently than once every 2 weeks. The sessions are generally 30-60 minutes in duration. Periodic follow-up and evaluation should be documented by the physician at least every 30 days during the course of the rehabilitation.

For the purposes of this demonstration, vision rehabilitation services will not be subject to physical or occupational therapy caps.

CMS has established four different series of temporary demonstration procedure, or "G", codes to accommodate rehabilitation services for low vision. Each code series corresponds to the low vision rehabilitation professional that provided the service. These codes will be published in the October release of the Medicare Physician Fee Schedule Data Base (MPFSDB).

G9041	qualified occupational therapist
G9042	certified orientation and mobility specialist
G9043	certified low vision rehabilitation therapist
G9044	certified vision rehabilitation therapist

Payable places of service (POS) for Part B claims are office (11), home (12), assisted living facility (13), group home (14), custodial care facility (33) and independent clinic (49). Facilities that are qualified to submit claims are outpatient hospital clinics (TOB 13x), Outpatient CAH clinics (TOB 85x), CORF (TOB 75x), and freestanding rehabilitation clinics (TOB 74x). Fiscal Intermediaries (FI) will use the claim related condition code 79 to indicate when services are provided outside the facility. When no condition code appears it will indicate that rehabilitation services were provided in the facility. FIs will not need to create an edit for facility place of service; however, providers will be required to indicate either no code or code 79 on claims. Facility claims will also use the revenue code 0949 (other rehabilitation services) in

addition to the demonstration procedure G-code, which indicates the type of professional who provided the rehabilitation service. This will apply to all institutional settings and CAH outpatient departments. CAHs that elect to use method II billing will use revenue code 0969 or revenue code 0962, whichever is most appropriate. Carriers will accept and process claims from qualified physicians when those claims include, 1) an appropriate ICD-9-CM code that supports medical necessity, 2) an appropriate rehabilitation procedure ("G") code for the demonstration, and 3) evidence of a written plan of care that specifies the type and duration of the rehabilitative services being furnished. The plan of care and date can be indicated in block 19 (Reserved for Local Use) of Form CMS-1500. Facilities shall use occurrence code 17 for date the plan of care was established or reviewed.

Medicare contractors shall use the most appropriate Medicare Summary Notice (MSN) messages unless specified otherwise in the business requirements. The following MSN messages will apply.

15.4 - The information provided does not support the need for this service or item.
16.2 - This service cannot be paid when provided in this location/facility.
16.43 -This service cannot be approved without a treatment plan and supervision of a doctor.
26.4 - This service is not covered when performed by this provider.

NOTE: The messages below are not currently in the Internet Only Manual (IOM) but are approved MSN messages.

15.22 The information provided does not support the need for this many services or items in this period of time so Medicare will not pay for this item or service.

15.22 La información proporcionada no justifica la necesidad de esta cantidad de servicios o artículos en este periodo de tiempo por lo cual Medicare no pagará por este artículo o servicio.

NOTE: The following messages are new and will be included in the IOM shortly.

New Message 60.13- This claim is being processed under a demonstration project. Services cannot be covered because you do not reside in one of the demonstration areas.

New Message 60.13- Esta reclamación está siendo procesada bajo un proyecto de demostración. Los servicios no pueden ser cubiertos porque usted no vive en una de las áreas de la demonstración.

New Message 60.14- This claim is being processed under a demonstration project. Services cannot be covered because your doctor does not have a practice in one of the demonstration areas.

New Message 60.14 - Esta reclamación está siendo procesada bajo un proyecto de demostración. Los servicios no pueden estar cubiertos porque su médico no tiene una oficina en una de las áreas de la demonstración.

Demonstration sites have not yet been determined. It is expected that sites may include entire states, parts of states, and/or major metropolitan areas. CMS will provide specific demonstration site information as soon as they have been established. The residence of the beneficiary receiving services and the physician or facility providing the services must be in the same demonstration locale (state, region, metropolitan area) as determined by matching primary residence and primary practice zip codes. In any case, no more than 1,100 zip codes are expected to be involved in the demonstration.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3816.1	The Medicare Contractor shall pay claims submitted by a qualified physician for low vision rehabilitation services provided by an occupational therapist or by a certified vision rehabilitation professional under the general supervision of the qualified physician. Qualified physicians for this demonstration are defined as ophthalmologists or optometrists (Physician specialty code 18 or 41). The supervising physician shall bill using the following demonstration HCPCS codes (G-codes) which will be published in the October release of the MPFSDB. G9041 qualified occupational therapist G9042 certified orientation and mobility specialist G9043 certified low vision rehabilitation therapist G9044 certified vision rehabilitation therapist 1. It will be the responsibility of the physician supervising the occupational therapist or certified vision rehabilitation professional to insure that the rehabilitation professional is certified and/or licensed to provide low vision rehabilitation services in the state in which the services are rendered. 2. It will be the responsibility of the physician supervising the certified vision rehabilitation			X			X			Qualified Physician, Rehabilita-tion Facility Qualified Physician Qualified Physician, Rehabilita-tion Facility Qualified Physician,

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	professional to develop a written plan of care and that it is reviewed at least every 30-days. This plan of care shall be made available to the appropriate Medicare contractor and will be subject to review at any time. Plans of care shall include, at a minimum the following: (1) Documentation of the level of visual impairment; (2) Specific measurable goals for rehabilitation and criteria by which the goals will be measured; (3) Description of specific rehabilitative services to be directed toward each goal; and (4) A reasonable estimate of the amount of treatment needed to reach the goals.									Rehabilita-tion Facility Qualified Physician
3816.1.2	The Medicare Contractor shall pay claims submitted by a qualified occupational therapist in private practice (OTPP) (code 67) for low vision rehabilitation services using HCPCS code G9041. A qualified OTPP is one who is legally authorized to engage in the private practice of occupational therapy by the State in which they practice as specified in 42 CFR, Volume 2, Sec. 410.59C(i) (ii), and practice only within the scope of their license, certification, or registration.			X			X			
3816.1.3	The Medicare Contractor shall pay claims submitted by a qualified rehabilitation facility or clinic for low vision rehabilitation services provided by occupational therapist or by a certified vision rehabilitation professional under	X				X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	general supervision, where there is a contractual agreement between the vision rehabilitation professional and the facility. Claims shall be submitted as if it were a Part B claim using the location of the facility as the basis for jurisdictional pricing and reimbursement. CAH payment method 1&2 apply. Qualified rehabilitation facilities or clinics include: -Outpatient hospital clinics-TOB 13x -Outpatient CAH clinics-TOB 85x -Comprehensive Outpatient Rehabilitation Facilities (CORF)-TOB 75x -Freestanding rehabilitation clinics & Facilities that bill Medicare for occupational therapy services-TOB 74x Home Health facilities are not included									
3816.2	Medicare contractors shall edit and process for demonstration G-codes when specific diagnosis codes are billed.	X		X		X	X			
3816.2.1	All claims shall contain the following information: 1. Demonstration procedure (G) code. 2. UPIN number for the referring/ supervising physician. Claims submitted for services without the name and UPIN of the referring/ordering physician will be returned as incomplete under 1833(e). 3. Specific ICD-9-CM diagnosis code (see list under Section B). Claims submitted	X X X X		X X X X		X X X	X X X			Billing provider must submit claims with minimum required information

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	without one of the"ICD-9-CM codes that support medical necessity" described in Section B in these business requirements will be denied under 1862 (a)(1)(A). 4. Place of service code. For physicians: Office – 11 Home – 12 Assisted living facility – 13 Group home - 14 Custodial care facility – 33 Independent clinic – 49 For facilities: Providers shall be instructed to use condition code 79 in form locators 24 - 30 of the HCFA 1450 when services are provided outside of the facility. No condition code will indicate services provided in the facility. 5. Revenue code 0949 (facilities only). CAHs electing method II shall use revenue code 0969 or revenue code 0962 whichever is most appropriate. 6. The date the plan of care was established or reviewed shall be submitted in form locators 32 - 35 using occurrence code 17 and the associated date. (facilities only) 7. The date of services shall not precede the date the plan of care was established or reviewed.	 X X X X		 X		 X X X X	 X			
3816.2.2	The Medicare contractor shall populate the demonstration field with Demo code 46 on the CWF record when demonstration G-codes are billed (carriers only)			X			X		X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3816.2.3	The Medicare contractor shall populate the CWF-HUOP record with Demo code 46 when demonstration G-codes are billed. (Intermediaries only)	X				X			X	
3816.3	1. Claims submitted where non-demonstration services are billed with demonstration services shall be returned as un-processable (RTP for intermediaries). Use RA reason code 96, remark code N61.	X		X		X	X			
	2. Claims submitted without one of the diagnosis codes that support medical necessity as described in Section shall be denied under 1862 (a)(1)(A). Use MSN 15.4, RA reason code 11, remark code MA63			X			X			
	3. Claims submitted that do not identify the physician as being either an ophthalmologist (18) or optometrist (41), or an occupational therapist in private practice (67) shall be returned as un-processable. Use MSN 26.4 (Carrier only), RA reason code 52.			X			X			
	4. Claims submitted that do not identify a qualified rehabilitation facility shall be returned to provider. Use MSN26.4	X				X				
	5. Claims submitted for services rendered in any place of service other than those indicated as payable shall be returned as un-processable. Use MSN 16.2 (Carrier only), RA reason code 58.			X			X			
	6. Claims submitted that exceed the limitation of service (no more than 24 units@ 15 minutes/90-day period) shall be rejected. CWF will create new edits to reject the incoming claim and the Auxiliary file where more than 24 units @ 15 minutes are billed in a 90 day	X		X		X	X		X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	period. Use MSN 15.22, RA reason code 119, remark code M139									
	7. Claims submitted that do not indicate that the plan of care has been reviewed within the past 30-days shall be returned as un-processable (RTP for Intermediaries). Intermediaries use occurrence code 17 and date the plan of care was established or reviewed on Form CMS-1450 or electronic equivalent. Carriers use field 19 of Form CMS-1500 to document compliance. Use RA reason code B5, remark code 141.	X		X		X	X			
	8. Claims submitted that do not indicate that the primary residence of the beneficiary and the practice address of the billing physician, OTPP, or facility providing the service are both in the same designated demonstration locale shall be denied. Use MSN 60.13 or 60.14, as appropriate.	X		X		X	X			
	9. Charges incurred for all denied claims shall be the responsibility of the provider or practitioner unless condition code 32 (ABN issued) is included on the claim. Use RA reason code 96, remark code M38.	X		X		X	X			
3816.4	Payment for the demonstration G-Codes shall be based on the current physician fee schedule. Jurisdictional pricing shall apply. TOB 85x shall be used for CAH Method I with revenue code 0949 to pay at 101% of reasonable cost. CAH method II shall pay at the professional rate using revenue code 0962 or 0969, whichever is most appropriate.	X		X		X	X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3816.4.1	CWF shall add the new G codes with an effective date of Oct. 1, 2005 with a TOS =Q.								X	
3816.5	All appropriate Medicare Part B deductibles and coinsurance amounts shall be applied to these services.	X		X						
3816.6	These services shall not be grouped into any APC group for payment.	X								Outpatient Code Editor/Pricer
3816.7	Contractors shall apply indications and limitations of coverage and/or medical necessity as follows:	X		X						
	1. Rehabilitation is medically necessary.	X		X						
	2. Beneficiary has moderate or severe visual impairment, due to disease or injury, which cannot be corrected through conventional refractive methods or surgery.	X		X						
	3. Beneficiary has a clear potential for significant improvement of the documented baseline reduced physical functioning.	X		X						
	4. That no more than 6 hours, or 24 units (15-minutes each) of rehabilitation occurs in any consecutive 90-day period.	X		X		X	X			
	5. CWF shall create new edits for the incoming claims and the Auxiliary file where more than 24 units of 15 minutes each (6 hrs) are billed in a 90-day period.								X	CWF will create a new edit for the 6 hours
	6. Demonstration-related rehabilitation services are not subject to therapy caps.	X		X		X	X			

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	7. CWF shall create a new auxiliary file that will store and display the Low Vision services. CWF will establish the initial date from the first claim. The initial date will not change.								X	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3816.8	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2005 **Implementation Date:** October 3, 2005 **Pre-Implementation Contact(s):** James Coan (410) 786-9168 **Post-Implementation Contact(s):** James Coan (410) 786-9168	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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